Compliance Plan

County of San Luis Obispo
Behavioral Health Department
2180 Johnson Avenue
San Luis Obispo, California 93401-4335

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Introduction

A. Overview

In mid-2000 the Behavioral Health Department ("Department"), through its Mental Health Services Compliance Committee, made a commitment to adhere to the regulations. When necessary, the Department sought independent and objective expert advice to support its Program. The Department continues to engage experienced consulting firms when needed to assist the Compliance Committee in monitoring the effectiveness of the Program and in conducting audits of its business processes and clinical practices consistent with applicable rules and regulations.

A written Department Compliance Plan is intended to codify core values, business processes and clinical practices that have been in place for many years. All affected members of the Department's work force as well as its contractors are committed to on-going behavior that reflects the Department-wide commitment to ethics, integrity and compliance articulated in this written Compliance Plan and the associated Code of Conduct.

In particular, the Department concurs with the OIG of the United States Department of Health & Human Services (DHHS) that quality of care is, and should be, the first priority. This Department-wide commitment to quality care supports the DHHS's and OIG's position that seeking reimbursement for substandard care is actionable under the False Claims Act (FCA) and Fraud Enforcement Recovery Act (FERA). The focus on quality care can be enhanced by the adoption of a mandated compliance program. For example, enhancing the accuracy and quality of documentation practices as part of an effective compliance program actually benefits the quality of consumer care throughout the Agency.

In addition to promoting quality of care and mitigating potential exposure to legal and regulatory liability, other important benefits of an effective compliance program (as outlined in the October 5, 2000 **Federal Register**) include but are not limited to:

1. Optimizing legitimate reimbursement for healthcare services provided by the Department;

2. Minimizing delays in legitimate claim payment to enhance the Department's revenue cycle;

3. Reducing or eliminating claim denials, disallowances and recoupment or refund of payments received in error as a result of external post-payment audits by federal and state agencies such as Recovery Audit Contractors (RAC), Zone Program Integrity Contractors (ZPIC) or Medicaid Integrity Contractors (MIC);

4. Protecting the confidentiality, privacy and security of protected health information (PHI) according to applicable federal Health Insurance Portability and Accountability Act (HIPAA) rules and state confidentiality laws;

5. Promoting a Department-wide culture of compliance and ethics that is embraced and supported by the County Board of Supervisors, Mental Health Board and Department Administration; and

6. Maintaining the Department's reputation for ethics, integrity and competence throughout the community it serves.

C. Essential Elements of an Effective Compliance Plan

Programmatic guidance defined by the OIG and DMH have identified the following components as essential elements of an effective compliance program. These essential elements as well as additional obligations articulated in FERA and Patient Protection and Affordable Act (PPACA) are described in more detail in subsequent sections of this written Compliance Plan.

- Implementation of a Code of Conduct and written policies and procedures (P&P);
- Designation of a Compliance Officer and Compliance Committee;
- Board of Supervisors governance;
- Effective lines of communication;
- Creation, retention and management of records and documents;
- Effective training and education;
- Compliance as element of work force performance goals and evaluation;
- Enforcement of standards of conduct through well-publicized Policy and Procedure and disciplinary guidelines;
- Internal auditing and monitoring;
- Responses to detected offenses and corrective action plans; and
- On-going risk assessment to ensure the Program's effectiveness and attention to evolving rules and regulations.

D. False Claims Act Training Under the Requirements of the Deficit Reduction Act

Beginning January 1, 2007 the Department complied with Federal and State requirements mandating employee and contractor education on the subject of preventing and reporting false claims, specifically information related to the FCA. The following information is presented as a part of the Department's commitment to meet these Federal and State mandates

False Claims Act (FCA) – Federal and State

The Federal FCA is broken into two main categories: Civil and Criminal.

- Civil – The civil portion of the Federal Claims Act prohibits any individual, group, organization from knowingly submitting, or causing to be submitted, a false or fraudulent claim for payment to the US government. The civil penalty for each individual claim (i.e. each service billed) is three times the amount of the claim, plus $5,000 - $10,000 for each fraudulent claim. (31 U.S.C. Section 3729 (a)) The government does not have to prove intent to defraud for financial gain, only that the claims submitted were not valid. A claim can be considered not valid for a variety of reasons including claiming services that were not provided, lack of documentation such as a missing progress note, documentation that does not support what was billed, or lack of documented medical necessity. Additional areas of healthcare Fraud, Waste and Abuse (FWA) include billing services individually that were actually a part of a bundled program, failure to report overpayment, duplicate billings, or billing for services outside the scope of practice of the rendering clinician. A

FCA action may be brought by the U.S. Government or by a private citizen. A lawsuit brought by a private citizen is referred to as "Qui Tam" or "Whistleblower". In the case of a Qui Tam or Whistleblower lawsuit, the person who brought the lawsuit is eligible to receive a percentage of money recovered, typically 10 to 25 %.

- Criminal – This portion of the FCA differs from the civil action in that it involves willful misrepresentation, in either documentation or verbal statement, for financial gain. Willful misrepresentation can take many forms including deliberately falsifying documentation for payment, deliberately covering up or hiding information about a false claim, lying to an investigator, or obstructing an ongoing investigation related to false claims action. If an individual is found guilty of these charges, there are both financial penalties and possible imprisonment for up to five years.

Federal Whistleblower Protections [31 USC Section 3730 (h)] protects employees against discharge, demotion, suspension, threats, harassment, or discrimination by the employer because of lawful acts done by the employee in cooperating with the FCA. This includes investigation for, initiation of, testimony for, or assistance in an action filed (or one in the process of being filed) under this section.

Patient Protection and Affordability of Care Act (PPACA), Section 6401 and 6402(d)

Certain provisions embedded in PPACA mandate that healthcare providers who receive payments – directly or indirectly – from federally-funded health care programs must have a compliance program based on OIG programmatic guidance and applicable state laws as a condition of enrollment in these programs. Mandatory compliance programs for providers of mental health services in California have been a regulatory requirement since 2002.

Other provisions require that providers that have received an overpayment in error must report and refund the overpayment to the applicable government agency or contractor and/or to the Secretary of DHHS within 60 days after receipt of the overpayment or the date the corresponding cost report is due, whichever is later.

Additionally, PPACA introduces new obligations related to the following mandates:

- **Accountability**: an effective Program should incorporate accountability requirements for compliance activities from the governing board down to individual members of the work force. The focus of such efforts should identify and monitor risk areas in combating FWA, with emphasis on value-based and outcome-oriented processes.

  Another area of concern is the status of individual and organizational enrollment in federally-funded health care programs. There should be processes as well as policy and procedure designed to address the possibility of exclusion from such programs as a result of "knowingly" making or causing to be made a false statement, omission or misrepresentation of a "material" fact in an enrollment application, agreement, bid, or contract."

  - **Transparency**: Provider operations should rely on the adoption of technologies and systems that promote transparency, especially to detect, remedy and report non-compliant or unethical practices. Inherent in this Transparency mandate is the need for an on-going auditing and monitoring program designed to detect and address non-compliant or unethical behaviors

throughout the organization.

In particular, attention to real or perceived conflicts of interest, inducements and non-permissible referrals must be demonstrated through documented compliance action reports. Prompt detection and refunding of overpayments received in error is another obligation of Transparency.

- **Quality**: Quality is an on-going compliance obligation, with renewed vigilance and enforcement action under PPACA. Seeking reimbursement for substandard care is now actionable under FCA. Enforcement actions include civil and criminal penalties as well as administrative sanctions under the "Worthless Services" theory.

Thus, it is essential for a provider organization to develop and implement evidence-based practice guidelines; appropriate documentation practices; and processes for capturing and reporting quality data as a condition of participation. Adherence to evidence-based practice guidelines for medication management and psychotherapy services with a diverse population is a good standard to follow.

Fraud Enforcement and Recovery Act (FERA)

Since its adoption in 2009, FERA has expanded considerably the language of FCA. As a result of language amendments in FERA, liability under FCA has been expanded to include any individual who "knowingly presents, or causes to be presented, to an officer or employee of the federal government or a member of the U.S. Armed Forces a false or fraudulent claim for approval or payment." The implications of this amendment extend to knowingly retaining an overpayment received in error.

Compliance responsibilities under FERA must include appropriate and effective monitoring systems and processes to ensure closer attention to deficiencies in coding, documentation and billing practices that might lead to inappropriate overpayments. At the same time, transparency obligations mandate prompt responses once such overpayments are detected in order to mitigate sanctions and penalties.

The California False Claims Act (Ca FCA)

The California FCA has many similarities to the federal FCA. There is no requirement to prove intent to defraud for financial gain, only that the claim submitted is not valid. The determination that a claim is not valid is much the same as with the federal FCA: missing documentation; documentation that does not speak to service billed; lack of medical necessity; duplicate billings, outside scope of practice; etc. The state FCA carries similar financial penalties including triple the amount of each claim, with up to $10,000 of additional penalty for each claim. Like the federal FCA, there can be a "Qui Tam," or "Whistleblower" action brought by an individual on behalf of the government, and if money is recovered, the individual who initiated the Qui Tam action will be entitled to a percentage of the recovery, typically between 15 to 33%.

Whistleblower Protections – Under the DRA, California Statute (Government Code Section 12653) provides protection for employees and contractors by preventing employers from making, adopting, or enforcing any rules, regulations or policies that would prevent an employee, or contractor from disclosing information to a government or law enforcement agency related to a false claims action. The statute also states that no employer shall discharge, demote, suspend, threaten, harass, deny promotion to, or in any other manner discriminate against an employee, or contractor because of their lawful acts in disclosing information to a government or law enforcement agency related to a false claims action. This

includes participating in an investigation for, initiation of, testimony for, or assistance in, an action filed (or in the process of being filed) under the California FCA.

E. Code of Conduct and Ethics

The Department is firmly committed to full compliance with all federal and state laws, regulations, rules and guidelines that apply to the Agency's operations and services. At the core of this commitment are actions of the employees and contractors of the Department, and the manner in which they conduct themselves in providing direct or indirect service to our clients. To ensure that commitment is shared by its employees and contractors, the Department has established the following Code of Conduct and Ethics. Every Department employee and contractor shall be required to certify his or her acceptance of the code before providing services for Behavioral Health Department.

Department Code of Conduct

The highest levels of management at the Department are committed to responding appropriately when a possible compliance violation is detected.

The Department's governing authority, administrators and providers shall be aware that violations of the Department's Program, significant failures to comply with applicable Federal or State law, and other types of misconduct threaten the Department's status as a reliable, honest, and trustworthy provider of health care in San Luis Obispo County.

1. **Act with integrity:**

   We work together, according to the same standards and core beliefs, to foster an environment where integrity and responsible business conduct are the cornerstones of who we are and what we do in support of the Department's mission.

2. **Ask questions, seek guidance and raise concerns:**

   Accountability is a significant part of our culture and one of the most important things you can do to demonstrate personal accountability is to ask questions, seek guidance or raise concerns. Anyone who in good faith asks questions, seeks guidance or raises a concern is doing the right thing. Everyone makes honest mistakes, but there's no such thing as an honest cover-up.

3. **Treat each other with respect and dignity to foster a safe and ethical workplace:**

   Treating each other with dignity and respect is the foundation of good conduct and helps maintain a safe and ethical workplace that upholds the Agency's reputation in the community we serve. It shows we care about people as individuals and acting with integrity means valuing and respecting the unique character of each colleague and his or her contribution to the success of the Department.

4. **Avoid conflicts of interest:**

As public servants, we must avoid any activity or personal interest that creates or appears to create a conflict of interest with respect to our responsibilities as representatives of the Agency. A conflict of interest arises when personal, social, financial or political activities have the potential of making it difficult for the Department to fulfill its mission in the best interest of the people we serve.

5. **Interact appropriately with our customers:**

Our customers are the residents of the County of San Luis Obispo to whom we provide necessary healthcare services. Our culture highlights that the value of our services begins with our customers. We foster longstanding relationships with our customers to better understand their healthcare needs and to address these needs in an ethical and compliant way.

We must interact appropriately with our customers and pay particular attention to the special rules that apply when dealing with governmental officials, entities as well as regulatory or law enforcement agencies.

We will refrain from soliciting or accepting any donations, grants, scholarships, subsidies, support or gifts that would result in even a perception of conflicts of interest. We will not offer or provide to our customers improper inducements so that we may seek inappropriate reimbursement from federally-funded health care programs.

6. **Promote the quality of our healthcare services:**

The quality and integrity of our healthcare services are critical to our success and essential in helping our customers with their healthcare needs. Our commitment to quality care is Department-wide. We are all responsible, directly or indirectly, for providing the highest quality of care possible. Providing substandard care places the Department at risk with regulatory agencies under the FCA and may harm its reputation in the community we serve.

7. **Adhere to governmental agencies, their representatives and regulations:**

We work in a highly regulated industry and must follow the rules and requirements set by various federal and state regulatory agencies.

We frequently interact with government agencies, officials and employees through normal business relationships and less frequently during compliance audits and investigations. In every instance, we should exhibit key elements of our belief in mutual respect and appreciation. We must apply high ethical standards and comply with applicable laws and regulations, including the special rules, laws and regulations that apply to governmental agreements or contracts in the delivery of our services.

8. **Maintain accurate and complete documentation:**

Directly or indirectly, we make decisions every day based on the information that is recorded by other colleagues at all levels of the Department.

It is critical that those who create or maintain reports, records or any other information review the integrity and accuracy of that information and never create a false or misleading document. This includes, but is not limited to: medical records and other clinical data; claims and billing statements; related accounting entries and adjustments; expense reporting; time reporting; production and quality improvement records; and documents filed with or submitted to governmental, law enforcement or regulatory agencies.

9. **Protect confidential information and assets**:

In addition, we will, properly and efficiently, use and take all reasonable precautions to safeguard the confidentiality, privacy and security of protected health information (PHI) according to federal HIPAA rules and consistent with State confidentiality law.

PHI created, obtained, compiled and maintained by or on behalf of the Department is the legal responsibility of the Department. We will treat PHI and other confidential information about our customers and the Department with the utmost respect. Likewise, we will respect and protect the physical assets (e.g. computers, personal electronic devices, furniture, buildings, vehicles, etc.) of the Department that have been entrusted to us.

a. All employees and contractors will be responsible for being familiar with the most recent version of the Department Policies and Procedures, as they relate to their duty assignments, and Compliance Plan. They will acknowledge their familiarity with the Department's Compliance Plan, Code of Conduct and Ethics and HIPAA policies on an annual basis.

b. Organizational Providers will document their understanding of the Department's Compliance Plan and provide assurance that their organizations Policy and Procedures include provisions of the said Compliance Plan. Each Organizational Provider will be required to certify annually that their organization adheres to the Department's Compliance Plan and Code of Conduct and Ethics.

c. Individual Providers will adhere to the professional and ethical standards of their respective licensing agencies and professional organizations and federal income tax regulations, as well as their contractual obligations with San Luis Obispo County. Individual Providers will review and sign the Department's Code of Conduct and Ethics when they initiate or renew a contract.

d. All employees and contractors of the Department shall treat other employees, contractors, clients, and customers ethically, fairly and with dignity and respect.

e. No employee contractor shall engage in any activity in violation of any of the policies and procedures set forth by the Department, nor shall any employee or contractor engage in any other conduct which violates health service-related federal, state or local law in the provision of services on behalf the Department. When in doubt about policies or interpretation of regulations, employees and contractors shall consult with their supervisors.

f. The Department's clients and the public at large have a right to expect that services provided by the Department will be rendered in a professional manner in accordance with legal mandates including Title 42, CFR, Section 438.100 which states that every beneficiary has the right to be

treated with respect and with due consideration for his or her dignity and privacy.

A copy of this Code of Conduct and Ethics shall be provided to all employees of the Department facilities at the time of initial hiring and annually thereafter. A copy of this Code of Conduct and Ethics shall also be furnished to contractors, including all independently contracted health care providers for their signature, at the time a contract is entered into or renewed.

Section 1

CONDUCTING INTERNAL MONITORING AND AUDITING

An ongoing monitoring and auditing is important to maintain a successful and effective Program. This ongoing evaluation includes, but is not limited to, monitoring and auditing of billing and reimbursement standards to ensure the procedures and supporting documentation practices are current and accurate. Through this activity, adjustments will be made to ensure the effectiveness of the compliance program (i.e., whether individuals are properly carrying out their responsibilities and claims are submitted appropriately).

A. Voluntary Initial and Follow-up Compliance Auditing Process

As noted by the OIG in the October 5, 2000 **Federal Register**, a self-audit is an excellent method to ascertain what, if any, problem areas exist and to focus on the risk areas that are associated with those problems.

1. Management Commitment to Ensure Compliance

As an example of this effort, at the request of MHS, an on-site assessment of specific reimbursement procedures and compliance issues was conducted October 16-17, 2000 by Rising Sun Consulting Associates, a consulting firm which works exclusively with behavioral health agencies and practitioners.

The purpose of this audit was to determine whether:

- Bills are accurately coded and accurately reflect the services provided (as documented in the medical records);
- Documentation is being completed accurately and correctly to support the billing codes reported in claims submitted to federally-funded health care programs;
- Services or items provided are reasonable and necessary; and
- Any incentives for unnecessary services exist.

2. Areas of Focus in the Voluntary Audit Process

This audit examined, in detail, the billing and reimbursement process at the Department focusing specifically on Medicare and Medi-Cal. Some of the areas examined in this audit included the following:

- CPT code usage
- Medical Record Documentation
- Advanced Beneficiary Notices
- Waiver of Coinsurance
- Provider Credentials and Qualifications Consistent With Their Scope of Practice
- Medicare and Medi-Cal participation
- Timely Filing Requirements

- Data Integrity
- Compliance Initiatives
- Standards and Procedures
- Local and National Coverage Determinations and Other Directives
- Medical Necessity
- Self-Referrals
- Voluntary Refunds
- Non-Covered Services
- Ineligible Providers
- Education and Training
- Business Office Staffing

3. Continuing Efforts to Ensure Compliance

Since the initial baseline audit report, MHS continues to work with representatives from other consulting firms to monitor compliance and conduct education and training programs.

4. Pre-payment Review of Medicare Part B Claims

Mental Health Chart notes for sampled Medicare Part B services are reviewed by an independent consulting firm to confirm medical necessity, provider eligibility, and that the documentation meets the requirements for the CPT code selected.

Section 2

IMPLEMENTING COMPLIANCE AND PRACTICE STANDARDS

Because the Department is part of a county agency, a number of documents and policy statements exist which address standards and procedures that affect compliance and compliance issues. These policy statements address patient care, personnel matters, and standards and procedures on complying with federal and State law. The Compliance Officer and the Compliance Committee review these documents on a regular basis.

A. Specific Areas of Risk

The Department makes every effort to identify the potential risk areas noted by the OIG in the October 5, 2000 **Federal Register** and its annual work plans. These risk areas include:

1. Coding and Billing

Because coding and billing are such integral components of the Program, a full-time Billing and Reimbursement Manager was added to the Department staff in mid-2001.

This Manager continually monitors all activities related to billing and coding and ensures that the following errors do not occur:

- Billing for items or services not rendered or not provided as claimed
- Submitting claims for equipment, medical supplies and services that are not reasonable or not necessary
- Double billing resulting in duplicate payment
- Billing for non-covered services as if covered
- Knowing misuse of provider identification numbers, which results in improper billing
- Unbundling (billing for each component of the service instead of billing or using an all-inclusive code)
- Failure to properly use coding modifiers
- Bundling
- Up-coding the level of service provided.

2. Reasonable and Necessary Services

The Agency makes every effort to comply with Medicare's definition of reasonable and necessary services.

Psychiatrists and other clinicians eligible for "provider transaction account numbers" and NPI at the Department know that Medicare, Medi-Cal (and many insurance plans) may deny payment for a service that is not reasonable and necessary according to National and Local Coverage Determinations (NCD and LCD), their benefit coverage and reimbursement rules.

3. Documentation

The psychiatrists, other clinicians, and administrative personnel at the Department are aware that timely, accurate and complete documentation is important to quality patient care and essential for proper reimbursement. Additionally, staff are informed that documentation serves a second function when a bill is submitted for payment. It is verification that coding and billing practices are accurate and supported by the corresponding medical record documentation. In addition to facilitating high quality patient care, the clinical staff at the Department is committed to a properly documented medical record that verifies and documents precisely what services were actually provided.

Internal documentation guidelines of the Department include, but are not limited to the following requirements:

a. The medical record must be complete and legible. Each encounter, visit, or progress note must be signed, dated and document billing time.
b. The documentation of each patient encounter includes the reason for the encounter; any relevant history; physical examination findings when appropriate; prior diagnostic test result; assessment, clinical impression, or diagnosis; plan of care; and date and legible identity of the observer.
c. If not documented, the rationale for ordering diagnostic and other ancillary services can be easily inferred by an independent reviewer or third party who has appropriate medical training.
d. Documentation and the medical record support CPT and ICD-9-CM codes used for claims submission.
e. Appropriate health risk factors are identified. The patient's progress, his or her response to, and any changes in, treatment, and any revision in diagnosis are documented.

4. Improper Inducements Kickbacks and Self-Referrals

Business relationships of the Department with hospitals, hospices, nursing facilities, home health agencies, durable medical equipment suppliers, pharmaceutical manufacturers and vendors are proper and comply with all Federal and State anti-kickback statutes.

The staff at Human Resources Department regularly reviews all relevant OIG Special Fraud Alerts and Advisory Opinions that address the application of the anti-kickback and physician self-referral laws to ensure that the standards and procedures reflect current positions and opinions.

5. Other Compliance-Related Activities

- **OIG and Medi-Cal Excluded Individuals Database**

As new providers make application for employment, their social security number and any previously assigned provider numbers are checked against the OIG and Medi-Cal Excluded Individuals Database. Contractors are expected to monitor the Excluded List for all

employees involve in direct services or services supporting direct service to the Department's clients. All employee and employees of Organizational Providers should have these checks done at least annually.

- **Medicare CPT Code Utilization Profile**

Periodically, the Department requests and reviews each provider's CPT Code (Procedure Code) Utilization Profile. This information informs administration and the providers how their CPT/Procedure Code usage compares with other providers in the region.

B. Health Insurance Portability and Accountability Act (HIPAA) Compliance

As part of the overall Program, the Department is committed to meeting all HIPAA requirements. The Department has met the key HIPAA dates for transaction and code sets compliance and the date for implementation of privacy and security rules.

1. Transactions and Code Sets Compliance

   The HIPAA compliance issues have been addressed by billing software vendors.
   Non-electronic billing conforms to the Transactions and Code Set requirements. Where applicable, the Department will meet deadlines established for electronic transmission compliance.

2. Privacy Practices Compliance

   The following are Department's procedures that contribute to compliance with the HIPAA Privacy standards:

   a. Provide patients a Notice of Privacy Practices that outlines what will be done with clients' protected health information and document the clients' written acknowledgment that they have received the notice.

   b. Ensure staff and others have access to the minimum necessary amount of Protected Health Information about clients that is required to do their jobs. Written policies concerning this access shall be maintained and staff shall be trained accordingly.

   c. Set up reasonable safeguards to prevent incidental exposures, such as a client overhearing information about another client receiving services at the Department.

   d. The Privacy Official is the Compliance Officer, who is in charge of making certain that the Department is compliant with HIPAA. The Compliance Officer will also oversee and Public will have designate staff as HIPAA Officers to engage in day-to-day HIPAA activities. These designated HIPAA Officers will consult with the Privacy Official on technical and operational questions and are members of the Compliance Committee.

   e. Get authorization from patients to release protected health information for any purpose

other than treatment, including payment, or other activities including marketing.

f. Set up business associate agreements with vendors who work on behalf of the Department who are not employees but who have access to medical or payment information about patients. These agreements require the vendor to protect the privacy of Department clients.

g. Provide patients with access to their medical records.

3. Security Practices

The Department Adheres to the Security Policies and Practices outlined in the County of San Luis Obispo Information Security Program. This program provides a framework for the Department's operational and strategic decisions related to its electronic computing environment and regulates staff behavior within that environment. Before accessing any Department computing assets, all system users, including temporary and contract staff, must sign the "Acceptable Use Policy Acknowledgement" which requires compliance with the Countywide Security Program.

The County's Information Security Program regulates a broad range of issues including the acceptable use of PCs, internet, e-mail and other electronic communication; guidelines and requirements for storing and transporting data on portable computing equipment; managing passwords; network security practices, and managing sensitive or protected data.

Furthermore, the Department ensures that the access to PHI and disclosure of PHI adhere to HIPAA Federal Regulations and California Welfare and Institution Codes. In accordance with the 2009 California Law (SB 541, AB 211), all reportable breaches are reported to the appropriate State and Federal agencies and logged.

Section

3

DESIGNATION OF THE COMPLIANCE OFFICER

The Behavioral Health Administrator shall appoint a Compliance Officer who chairs the Compliance Committee, with representatives from various appropriate programs. The Department is committed to creating a non-retaliatory environment where complaints, problems, and errors can be discussed and resolved without fear. All staff members should feel comfortable in addressing ethical concerns, legal issues, and complaints of impropriety.

The Compliance Committee and Compliance Officer shall work to prevent and resolve billing, coding, and documentation problems internally before the problems rise to the level of fraud or abuse.

The Compliance Officer shall be a key member of the administrative team and provides feedback to administration.

In general, the Compliance Officer shall be responsible for auditing and monitoring all provider numbers, clinical documents, coding records, and billing records.

The following is an expanded list of duties of the Compliance Officer and the Compliance Committee:

1. Oversee and monitor the Compliance Program and provide leadership and guidance to the Department Compliance Committee.
2. Report on a regular basis to the Behavioral Health Administrator and the Health Agency Director and appropriate staff on compliance issues.
3. When applicable, review employees' certifications which state that the employees have received read and understood the standards of conduct.
4. Establish methods, such as periodic audits, to improve the Department's efficiency and quality of services, and to reduce the Department's vulnerability to fraud and abuse.
5. Periodically revise the compliance program to address changes in the needs of the Department or changes in the law and in the standards and procedures of Government and private payer health plans.
6. Develop, coordinate and participate in a training program that focuses on the components of the compliance program and seeks to ensure that training materials are appropriate.
7. Ensure that the HHS-OIG's List of Excluded Individuals and Entities, and the General Services Administration's (GSA's) List of Parties Debarred from Federal Programs have been checked with respect to all employees, medical staff and independent contractors.
8. Investigate any report or allegation concerning possible unethical or improper business practices, and monitor subsequent corrective actions and/or compliance.

Section

4

EDUCATION AND TRAINING PROGRAMS

A. Commitment to Education and Training

The Department is committed to providing the education and training programs needed to ensure compliance with Federal and State regulations.

The objectives of the Department compliance training program are:

- Determine training needs (both in coding and billing and documentation compliance).
- Determine the type of training that best suits the Department's needs (e.g., seminars, in-service training, self-study or other programs).
- Determine when and how often education is needed and how much each employee or provider should receive.

B. Outside Consultants and Specific Topics Covered

1. Outside Consultants may be retained for On-Going Compliance Education and Training in the following areas but not limited to:

    - HIPAA Compliance
    - CPT Coding for Behavioral Health
    - Medicare and Medi-Cal Billing Code Differences
    - Claim Development and Submission Process
    - Signing a Form for a Physician without Authorization
    - Treatment Planning
    - Medical Necessity Requirements
    - Billing for Non-physician Providers
    - "Incident to" Billing
    - Medical Records Documentation
    - Review of current Medicaid and Medicare Newsletters
    - Provider Numbers
    - Insurance Verification Process
    - Medicare and Medicaid Denials
    - Standards of Business Conduct
    - Consequences of Violating Federal and State Health Care Laws

2. Areas of Focus in Compliance Training

- CPT and ICDM-9 and *DSM* Coding
  The appropriate CPT and ICDM-9M and DSM coding for the professional services of the MHS providers have been and continue to be a major focus of educational efforts. These areas shall continue to focus on specific billing issues pertaining to each program. Additionally, the credentialing requirements for the clinical professionals and the chart note documentation requirements shall be enhanced by specific ongoing training.

  All clinical professionals shall have the knowledge that CPT code selection is the responsibility of the provider of service and that the code billed should be the code that most clearly reflects the service provided and documented in the medical record.

- Medical Record Documentation
  Several medical record documentation reviews for the providers of Department have been conducted to determine if documentation efforts meet Federal and State criteria.

Standards for Department clinicians require that each chart note must contain the following information:

- Name of the patient
- Date of service
- Legible signature of provider with credentials (MD, OD, RN, etc.)
- Reason for the encounter (Medical necessity)
- Changes in client's condition (mental, physical) since last encounter
- Examination (Mental status or current complaint)
- Relevant health risk status
- Reasons for and results of any lab, x-ray and other ancillary services (within staff's scope of practice)
- Patient's response to treatment, with appropriate interval history when applicable
- Full present diagnosis. Any change and relevant partial diagnosis
- Plan for care, including all medications, frequency and dosage, psychotherapy, patient/family education, interventions and follow up
- All referrals and/or consultations and results

Providers are obligated to ensure medication management and psychotherapy services rendered and documented adhere to the current Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

Section

5

RESPONDING TO DETECTED OFFENSES AND DEVELOPING CORRECTIVE ACTION INITIATIVES

When compliance violations are discovered within the Department, immediate, decisive steps shall be taken to correct the problem.

In order to minimize compliance violations, Department staff and the Compliance Committee shall continually monitor:

- Significant changes in the number and/or types of claim rejections and/or reductions.
- Correspondence from the carriers and insurers challenging the medical necessity or validity of claims.
- Illogical patterns or unusual changes in the pattern of CPT-4, HCPCS or ICD-9 code utilization.
- High volumes of unusual charge or payment adjustment transactions.

If compliance violations are found within the Department, the appropriate, corrective action shall be taken including employee training or counseling, appropriate revision of policy, or disclosure to an appropriate Government authority or law enforcement agency. The Department shall make prompt refunds of any overpayments (even minimal amounts) to all insurance companies. The Department shall maintain an internal audit process in place to prevent duplicate or inappropriate billing.

If, after investigation, it is found that the violation was due to the 3rd party (State Department of Mental Health, Software Vendor), the Department shall keep a record of the incident and provide feedback to the appropriate agency.

Section

6

DEVELOPING OPEN LINES OF COMMUNICATION

All Department clinical and administrative personnel as well as contractors are encouraged to communicate openly with supervisory personnel and each other. The Department shall maintain an environment in which employees can ask questions and are encouraged to develop a mindset focused on preventing problems.

Clinical and administrative staff members shall attend regularly scheduled staff meetings and are encouraged to participate in discussion and decision-making.

Since the Department is publicly funded, there shall be an "open door" policy for psychiatrists, staff, and other employees to discuss compliance issues with the Compliance Officer and any other member of the upper-level management team. Written communications marked "confidential" may also be sent or e-mailed to the Compliance Officer's attention.

In addition, the Department maintains a confidential Compliance Hotline for reporting suspected inappropriate or non-standard practices related to documentation, coding, billing or clinical issues. That number is
877-842-1893.

The Department's Compliance Program encourages open communication by:

a. Requiring that employees report conduct that a reasonable person would, in good faith, believe to be erroneous or fraudulent.
b. Creating a user-friendly process for effectively reporting erroneous or fraudulent conduct.
c. Maintaining provisions in the standards and procedures that state that a failure to report erroneous or fraudulent conduct is a violation of the Program.
d. Utilizing a process that maintains the anonymity of the person(s) involved in reported possible erroneous or fraudulent conduct and the person(s) reporting the concern.
e. Maintaining provisions in the standards and procedures that there will be no retribution for reporting conduct that a reasonable person acting in good faith would have believed to be erroneous or fraudulent.

Section

7

ENFORCING DISCIPLINARY STANDARDS THROUGH WELL-PUBLICIZED GUIDELINES

The Department strives to be fully compliant with all of the complex rules and regulations governing the health care industry. Accordingly, the Department has established billing and compliance policies that are designed to ensure accurate coding, billing, and claims submission.

Because Federal and State laws govern the billing and reimbursement policies at the Department, it is of crucial importance that the Department responds to incidents of non-compliance fairly, directly, specifically and in proportion to the potential risk of harm to the Department.

The Department shall maintain measures to ensure that Department employees have knowledge of the consequences of behaving in a non-compliant manner. Policies and procedures shall be in place to ensure adherence to the Program's Code of Conduct. Non-compliant practices will be subject to appropriate, progressive disciplinary action up to and including termination.

Disciplinary actions of enforcement for county employees will follow the San Luis Obispo Human Resources Guidelines for progressive discipline as outlined in the Supervisory Practice Guidelines.

Although not necessarily disciplinary in nature, the Department's staff members whose billing practices fail to meet appropriate standards may be required to attend educational seminars, be assigned to report on those educational seminars or educate fellow staff members on billing compliance issues.

Failure to adequately comply with the Department's compliance policies and procedures shall also be included in a staff member's annual performance evaluation.

Appendix A

Civil Monetary Penalties (CMP's) for Medicare Fraud and Abuse – Supplemental Detail of types of questionable Activities which are basis for DRA Enforcement

(Copied from CMS website at the following URL: http://cms.hhs.gov/provider/fraud/cmp2.asp)

DESCRIPTION OF CIVIL MONEY PENALTIES (CMPs)

In 1981, Congress added section 1128A (42 U.S.C. 1320a-7a) to the Social Security Act (section 2105 of Public Law 97-35) to authorize the Secretary of Health and Human Services to impose civil money penalties (CMPs). Since the enactment of the first CMP in 1981, Congress has dramatically increased both the number and types of circumstances under which CMPs may be imposed. Most of the specific statutory provisions authorizing CMPs also permit the Secretary to impose an assessment in addition to the CMP. An assessment is an additional money payment in lieu of damages sustained by the government because of the claim. Also, for many statutory violations, the Secretary may exclude the individual or entity violating the statute from participating in the Medicare program for certain specific periods of time.

In October 1994, the Secretary realigned the responsibility for enforcing these CMPs between the Health Care Financing Administration (HCFA) and the Office of Inspector General (OIG). HCFA was delegated the responsibility for implementing CMPs that involve program compliance; OIG was delegated the responsibility for implementing CMPs that involve threats to the integrity of the Medicare program, i.e., those that involve fraud or false representations. On August 21, 1996, the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) was enacted. This law provides for higher maximum CMPs ($10,000 per item or service in noncompliance instead of $2,000 per item or service), and higher assessments (three times the amount claimed instead of twice the amount) for some of the violations.

Although compliance can be compelled where necessary, it is primarily dependent on voluntary adherence by health care practitioners, suppliers, and the public. HCFA's effort to achieve compliance is directed toward promoting a clear awareness and understanding of the program. When efforts for achieving voluntary compliance fail, formal enforcement action (civil money penalties, assessments and exclusion from the program) will be undertaken.

The following is a synopsis of those authorities under which HCFA's Program Integrity Group may impose civil money penalties, assessments, and/or exclusions for program noncompliance:

(1) Section 1806(b)(2)(B) -- Any person or entity that fails to provide an itemized statement describing each item or service requested by a Medicare beneficiary. (This violation is subject to a CMP)

(2) Section 1833(h)(5)(D)--Any person that bills for a clinical diagnostic laboratory test, other than on an assignment-related basis. This provision includes tests performed in a physician's office but excludes tests performed in a rural health clinic. (This violation is subject to a CMP, assessment, and exclusion.)

(3) Section 1833(i)(6)--Any person that bills for an intraocular lens inserted during or after cataract surgery for which payment may be made for services in an ambulatory surgical center. (This violation is subject to a CMP.)

(4) Sections 1834(a)(11)(A) and 1842(j)(2)--Any supplier of durable medical equipment that charges for covered items (furnished on a rental basis) after the rental payments may no longer be made (except maintenance and servicing) as provided in section 1834(a)(7)(A). (This violation is subject to a CMP, assessment, and exclusion.)

(5) Section 1833(q)(2)(B)--When seeking payment on an unassigned basis, any entity that fails to provide information about a referring physician, including the referring physician's name and unique physician identification number. (This violation is subject to a CMP and exclusion.)

(6) Sections 1834(a)(18)(B) and 1842(j)(2)--Any durable medical equipment supplier that fails to make a refund to Medicare beneficiaries for a covered item for which payment is precluded due to an unsolicited telephone contact from the supplier. (This violation is subject to a CMP, assessment, and exclusion.)

(7) Sections 1834(b)(5)(C) and 1842(j)(2)--Any nonparticipating physician or supplier that charges a Medicare beneficiary more than the limiting charge as specified in section 1834(b)(5)(B) for radiologist services. (This violation is subject to a CMP, assessment, and exclusion.)

(8) Section 1834(a)(17)(C)--Any supplier of durable medical equipment that makes unsolicited telephone contacts with Medicare beneficiaries regarding the furnishing of covered services. (This violation is subject to an exclusion.)

(9) Sections 1834(c)(4)(C) and 1842(j)(2)--Any nonparticipating physician or supplier that charges a Medicare beneficiary more than the limiting charge for mammography screening, as specified in section 1834(c)(3). (This violation is subject to a CMP, assessment, and exclusion.)

(10) Sections 1834(h)(3) and 1842(j)(2)--Any supplier of durable medical equipment, prosthetics, orthotics, and supplies that charges for a covered prosthetic device, orthotic, or prosthetic (furnished on a rental basis) after the rental payment may no longer be made (except maintaining and servicing). (This violation is subject to a CMP, assessment and exclusion.)

(11) Section 1834(h)(3)-- Any supplier of durable medical equipment, prosthetics, and orthotics that makes unsolicited telephone contacts with Medicare beneficiaries regarding the furnishing of prosthetic devices, orthotics, or prosthetics. (This violation is subject to exclusion.)

(12) Sections 1834(j)(4) and 1842(j)(2)--Any supplier of durable medical equipment, prosthetics, orthotics, and supplies that fails to make refunds in a timely manner to Medicare beneficiaries (for items or services billed on a non-assigned basis) if the supplier does not possess a Medicare supplier number, if the item or service is denied in advance, or if the item or service is determined not to be medically necessary or reasonable. (This violation is subject to a CMP, assessment, and exclusion.)

(13) Section 1834(j)(2)(A)(iii)--Any durable medical equipment supplier that completes the medical necessity section on the certificate of medical necessity or fails to provide the fee schedule amount and the supplier's charge for the medical equipment or supply prior to distributing the certificate to the physician. (This violation is subject to a CMP.)

(14) Section 1834(k)(6) and 1842(j)(2) -- Any practitioner or other person that bills or collects for outpatient therapy services or comprehensive outpatient rehabilitation services on a non-assigned basis. (This violation is subject to a CMP, assessment, and exclusion)

(15) Section 1842(b)(18)(B)--For practitioners specified in section 1842(b)(18)(C) (physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, and clinical psychologists), any practitioner that bills or collects for any services on a non-assigned basis. (This violation is subject to a CMP, assessment, and exclusion.)

(16) Section 1842(k)--Any physician that presents a claim or bill for an assistant at cataract surgery performed on or after March 1, 1987. (This violation is subject to a CMP, assessment, and exclusion.)

(17) Section 1842(l)(3)--Any nonparticipating physician that does not accept payment on an assigned basis and that fails to refund beneficiaries for services that are not reasonable or medically necessary or are of poor quality. (This violation is subject to a CMP, assessment, and exclusion.)

(18) Section 1842(m)(3)--Any nonparticipating physician that bills for an elective surgical procedure on a non-assigned basis, charges at least $500, fails to disclose charge and coinsurance amounts to the Medicare beneficiary prior to rendering the service, and fails to refund any amount collected for the procedure in excess of the charges recognized and approved by the Medicare program. (This violation is subject to a CMP, assessment, and exclusion.)

(19) Section 1842(n)(3)--Any physician that bills diagnostic tests in excess of the scheduled fee amount. (This violation is subject to a CMP, assessment, and exclusion.)

(20) Section 1842(p)(3)(A)--Any physician that fails to promptly provide the appropriate diagnosis code or codes upon request by HCFA or a carrier on any request for payment or bill submitted on a non-assigned basis. (This violation is subject to a CMP.)

(21) Section 1842(p)(3)(B)--Any physician that fails to provide the diagnosis code or codes after repeatedly being notified by HCFA of the obligations on any request for payment or bill submitted on a non-assigned basis. (This violation is only subject to exclusion.)

(22) Section 1848(g)(1)(B)-- Any nonparticipating physician, supplier, or other person that furnishes physicians' services and bills on a non-assigned basis or collects in excess of the limiting charge or fails to make an adjustment or refund to the Medicare beneficiary. (This violation is subject to a CMP, assessment, and exclusion.)

(23) Section 1848(g)(4)--Any physician, supplier, or other person (except one excluded from the Medicare program) that fails to submit a claim for a beneficiary within one year of providing the service or imposes a charge for completing and submitting the standard claims form. (This violation is subject to a CMP and exclusion.)

(24) Section 1848(g)(3)--Any person that bills for physicians' services on a non-assigned basis for a Medicare beneficiary that is also eligible for Medicaid (these individuals include qualified Medicare beneficiaries). This provision applies to services furnished on or after April 1, 1990. (This violation is subject to a CMP, assessment, and exclusion.)

(25) Section 1862(b)(5)(C)--Any employer that (before October 1, 1998) fails to provide an employee's group health insurance coverage information to the Medicare contractor. (This violation is subject to a CMP.)

(26) Section 1862(b)(6)(B)--Any entity that fails to complete a claim form relating to the availability of other health benefit plans or provides inaccurate information relating to the availability of other health benefit plans on the claim form. (This violation is subject to a CMP.)

(27) Section 1877(g)(5)--Any person that fails to report information concerning ownership, investment, and compensation arrangements. (This violation is subject to a CMP, assessment, and exclusion.)

(28) Section 1879(h)--Any durable medical equipment supplier (including a supplier of durable medical equipment, prosthetic devices, prosthetics, orthotics, and supplies) that fails to make refunds to Medicare beneficiaries for items or services billed on an assigned basis if the supplier did not possess a Medicare supplier number, if the item or service is denied in advance, or the item or service is determined to be not medically necessary or reasonable. (This violation is subject to a CMP, assessment, and exclusion.)

(29) Section 1882(a)(2)--Any person that issues a Medicare supplemental policy that has not been approved by the State regulatory program or does not meet Federal standards. (This violation is subject to a CMP, assessment, and exclusion.)

(30) Section 1882(p)(8)--Any person that sells or issues nonstandard Medicare supplemental policies. (This violation is subject to a CMP, assessment, and exclusion.)

(31) Section 1882(p)(9)(C)--Any person that sells a Medicare supplemental policy and fails to make available the core group of basic benefits as part of its product line or fails to provide the individual (before the sale of the policy) with an outline of coverage describing the benefits provided by the policy. (This violation is subject to a CMP, assessment, and exclusion.)

(32) Section 1882(q)(5)(C)--Any person that fails to suspend a Medicare supplemental policy at the policyholder's request (if the policyholder applies for and is determined eligible for Medicaid) or automatically reinstates the policy as of the date the policyholder loses medical assistance eligibility (and the policy holder provides timely notice of losing his or her Medicaid eligibility). (This violation is subject to a CMP, assessment, and exclusion.)

(33) Section 1882(r)(6)(A)--Any person that fails to refund or credit as required by the supplemental insurance policy loss ratio requirements. (This violation is subject to a CMP, assessment, and exclusion.)

(34) Section 1882(s)(4)--Any issuer of a Medicare supplemental policy that does not waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods if the time periods were already satisfied under a preceding Medicare policy or that denies a policy, conditions the issuance or effectiveness of the policy, or discriminates in the pricing of the policy based on health status or other criteria. (This violation is subject to a CMP, assessment, and exclusion.)

(35) Section 1882(t)(2) -- Any issuer of a Medicare supplementary policy that fails to provide medically necessary services to enrollees through the issuer's network of entities, imposes premiums on enrollees in excess of the premiums approved by the State, acts to expel an enrollee for reasons other than nonpayment of premiums, does not provide each enrollee at the time of enrollment with specific information regarding policy restrictions, or fails to obtain a written acknowledgment from the enrollee of receipt of the information. (This violation is subject to a CMP, assessment, and exclusion.)

Medicare beneficiaries that believe a violation(s) described above has been committed against them or the Medicare program, should report the noncompliance to their local Medicare carrier or Fiscal Intermediary. The beneficiary should also be prepared to submit any documentation supporting their claim of noncompliance to the carrier or Fiscal Intermediary.

Appendix B List of Acronyms

CFR Code of Federal Regulations

CMP Civil Monetary Penalties

DHHS Department of Health & Human Services

DMH California Department of Mental Health

DRA Deficit Reduction Act

FCA False Claims Act

FERA Fraud Enforcement Recovery Act

FWA Fraud, waste and abuse

GSA General Services Administration's

HIPAA Health Insurance Portability and Accountability Act

LCD Local Coverage Determinations

MHS Mental Health Services

MIC Medicaid Integrity Contractors

NCD National Coverage Determinations

OIG Office of the Inspector General OIG

PHD Public Health Department

PHI Protected Health Information

PPACA Patient Protection and Affordable Care Act

RAC Recovery Audit Contractors

WPM Work Performance Memo

ZPIC Zone Program Integrity Contractors

Behavioral Health Department

STAFF SIGNATURE OF CERTIFICATION

1) I have received a copy of the County of San Luis Obispo Behavioral Health Department's Compliance Plan (Revised on 11-30-2010).

2) I am aware the Department's Compliance Plan is posted on the County's website.

3) I am familiar with the Departmental Compliance and HIPAA policies and procedures specifically related to my job duties and assignments.

4) I have participated in regular educational programs and refresher sessions offered by the Department related to the Department's Compliance Plan, HIPAA rules and requirements and related policies and procedures

5) I am aware of the False Claims Act provisions and penalties for inappropriate coding, documentation and billing of services. (pg. 3 & 4)

6) I am aware of the Whistle Blower Protection offered to all persons having knowledge of potentially illegal service provision, documentation or billing practices. (pg. 4)

7) I am aware of the Compliance Reporting Hotline at 1-877-842-1893.

8) I agree to abide by the Code of Conduct and Ethics set forth in this Plan on Page 6 of the Plan.

_____ _____

Print Your Name Date

_____

Signature

Behavioral Health Department

Organizational Provider Letter Of Certification

1) Our Organization acknowledges the receipt of a copy of the County of San Luis Obispo Behavioral Health Department's Compliance Plan (Revised on 11-30-2010).

2) We are aware the Department's Compliance Plan is posted on the County's website.

3) We are familiar with the Departmental Compliance and HIPAA policies and procedures specifically related to our job duties and assignments.

4) We have participated in regular educational programs and refresher sessions offered by the Department related to the Department's Compliance Plan, HIPAA rules and requirements and related policies and procedures.

5) We are aware of the False Claims Act provisions and penalties for inappropriate coding, documentation and billing of services. (pg. 3 & 4)

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8) Our Organization agrees to abide by the Code of Conduct and Ethics set forth in this Plan on Page 6 of the Plan.

_____ _____

Print Your Name Date

_____

Signature